

114TH CONGRESS
1ST SESSION

S. 1531

To reform the provision of health insurance coverage by promoting health savings accounts, State-based alternatives to coverage under the Affordable Care Act, and price transparency, in order to promote a more market-based health care system, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 9, 2015

Mr. CASSIDY (for himself, Mr. McCONNELL, Mr. CORNYN, Ms. COLLINS, Mr. INHOFE, Mr. COATS, Mr. ROUNDS, Mr. VITTER, Mrs. CAPITO, and Mr. WICKER) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To reform the provision of health insurance coverage by promoting health savings accounts, State-based alternatives to coverage under the Affordable Care Act, and price transparency, in order to promote a more market-based health care system, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Patient Freedom Act of 2015”.

1 (b) TABLE OF CONTENTS.—The table of contents for
 2 this Act is as follows:

Sec. 1. Short title; table of contents.
 Sec. 2. Sense of Congress.

TITLE I—HEALTH REFORM

Sec. 100. Definitions.

Subtitle A—Insurance Reforms

Sec. 101. State options in response to Burwell decision.
 Sec. 102. State alternative option.
 Sec. 103. Computation of monthly HSA deposit amount for deposit qualifying residents.
 Sec. 104. State options for improved access to health insurance coverage in each State.
 Sec. 105. Expanded access and patient protections.
 Sec. 106. Sunsetting certain ACA provisions; continuation of policies of covering adult children and not applying lifetime or annual limits.

Subtitle B—Medicaid

Sec. 111. Application of health savings accounts in relation to Medicaid.

Subtitle C—Provider Price Transparency

Sec. 121. Ensuring access to emergency services without excessive charges for out-of-network services.

TITLE II—REFORM OF TAX PROVISIONS RELATING TO HEALTH CARE

Subtitle A—Promotion of Health Savings Accounts

Sec. 201. Repeal of high deductible health plan requirement.
 Sec. 202. Treatment of HSA after death of account beneficiary.
 Sec. 203. Purchase of health insurance from HSA account.
 Sec. 204. Publishing of cash price for care paid through health savings accounts.

Subtitle B—Health Care Tax Credits

Sec. 211. Limited application of PPACA health premium credit.
 Sec. 212. New HSA credit.

3 **SEC. 2. SENSE OF CONGRESS.**

4 It is the sense of Congress that there is a need for
 5 legislation providing temporary transition funding for
 6 those who lose health insurance subsidies in the aftermath

1 of a Supreme Court decision in favor of the plaintiffs-ap-
 2 pellants in the case of King v. Burwell.

3 **TITLE I—HEALTH REFORM**

4 **SEC. 100. DEFINITIONS.**

5 In this title:

6 (1) **PATIENT-GRANT ELECTING STATE.**—The
 7 term “patient-grant electing State” means an elect-
 8 ing State that specifies under section 102(a)(4)(B)
 9 that it will carry out section 102(b) itself (and not
 10 to have section 102(b) carried out by means of the
 11 credit under section 36C of the Internal Revenue
 12 Code of 1986).

13 (2) **CHIP.**—The term “CHIP” means the Chil-
 14 dren’s Health Insurance Program established under
 15 title XXI of the Social Security Act (42 U.S.C. 1396
 16 et seq.).

17 (3) **CREDITABLE COVERAGE.**—The term “cred-
 18 itable coverage” has the meaning given such term in
 19 section 2704(c)(1) of the Public Health Service Act
 20 (42 U.S.C. 300gg–3(c)(1)), as in effect as of the day
 21 before the date of the enactment of this Act.

22 (4) **DEFAULT HEALTH INSURANCE COV-**
 23 **ERAGE.**—The term “default health insurance cov-
 24 erage” has the meaning given such term in section
 25 105(c)(2).

1 (5) DEPOSIT QUALIFYING RESIDENT.—The
2 term “deposit qualifying resident” has the meaning
3 given such term in section 102(b)(2).

4 (6) ELECTING STATE.—The term “electing
5 State” means a State that elects under section
6 101(a)(3) the alternative option described in section
7 102.

8 (7) HEALTH INSURANCE COVERAGE.—The term
9 “health insurance coverage” has the meaning given
10 such term in section 2791(b)(1) of the Public Health
11 Service Act (42 U.S.C. 300gg–91(b)(1)).

12 (8) HEALTH SAVINGS ACCOUNT; HSA.—The
13 terms “health savings account” and “HSA” mean a
14 health savings account established under section 223
15 of the Internal Revenue Code of 1986.

16 (9) HEALTH SAVINGS DEPOSIT.—The term
17 “health savings deposit” means a deposit made into
18 a health savings account pursuant to section 102.

19 (10) MEDICAID.—The term “Medicaid” means
20 the program under title XIX of the Social Security
21 Act (42 U.S.C. 1396 et seq.).

22 (11) MEDICARE.—The term “Medicare” means
23 the program under part A or B of title XVIII of the
24 Social Security Act (42 U.S.C. 1395 et seq.).

1 (12) PPACA.—The term “PPACA” means the
2 Patient Protection and Affordable Care Act (Public
3 Law 111–148), as in effect on the day before the
4 date of the enactment of this Act, unless otherwise
5 specified.

6 (13) QUALIFIED HEALTH PLAN COVERAGE.—
7 The term “qualified health plan coverage” means,
8 with respect to residents of a State, health insurance
9 coverage that meets applicable standards under
10 State law, which standards need not be the same as
11 that previously required of qualified health plans
12 under title I of PPACA, and includes a high deduct-
13 ible health plan (as defined in section 223(c)(2) of
14 the Internal Revenue Code of 1986) and includes
15 coverage under a group health plan.

16 (14) QUALIFIED RESIDENT.—The term “quali-
17 fied resident” means, with respect to a State for a
18 month, an individual who is a resident of the State
19 as of the first day of the month and is a citizen or
20 national of the United States or otherwise lawfully
21 residing in the State under color of law.

22 (15) SECRETARY.—The term “Secretary”
23 means the Secretary of Health and Human Services.

24 (16) STATE.—The term “State” means the 50
25 States and the District of Columbia.

(17) UNINSURED.—The term “uninsured” means, with respect to an individual, that the individual does not have creditable coverage.

4 Subtitle A—Insurance Reforms

5 SEC. 101. STATE OPTIONS IN RESPONSE TO BURWELL DECISION.
6

(a) IN GENERAL.—Each State may elect, through written notice to the Secretary after the date of the enactment of this Act and in accordance with this subtitle, 1 of following 3 options in relation to the implementation of title I of the Patient Protection and Affordable Care Act after the decision of the Supreme Court in *King v. Burwell*:

(1) CONTINUING IMPLEMENTATION OF PPACA,
INCLUDING FEDERAL SUBSIDIES THROUGH A STATE-
ESTABLISHED EXCHANGE.—Under current law, the
State establishing a health insurance Exchange
under title I of PPACA, which thereby permits the
continuation of Federal premium and cost-sharing
subsidies for coverage offered through the Exchange
as well as continuation of insurance and other re-
quirements under such title.

(2) REJECTION OF PPACA, INCLUDING ELIMINATION OF FEDERAL SUBSIDIES NOW PROVIDED THROUGH FEDERALLY ESTABLISHED EXCHANGE.—

1 Under current law, the State not establishing such
 2 an Exchange, potentially resulting, post-Burwell, in
 3 the loss of such Federal premium and cost-sharing
 4 subsidies and the continued application of other re-
 5 quirements under such title.

6 (3) ESTABLISHING NEW STATE AND MARKET-
 7 BASED ALTERNATIVE, WITH ALTERNATIVE PER CAP-
 8 ITA FEDERAL DEPOSIT SYSTEM.—The State imple-
 9 menting the alternative option described in section
 10 102, which includes—

11 (A) the waiver of most requirements im-
 12 posed under such title; and

13 (B) the provision of a new, HSA- and mar-
 14 ket-based deposit system for individuals who do
 15 not otherwise qualify for Federal or State sub-
 16 sidies for health benefits coverage.

17 If a State fails to make an election described in this sub-
 18 section, the State shall be deemed to have made the elec-
 19 tion described in paragraph (2). A State may, through
 20 written notice to the Secretary, change an election pre-
 21 viously made under this subsection.

22 (b) RELATION TO CURRENT MEDICAID ACA COV-
 23 ERAGE OPTION.—Nothing in this section shall be con-
 24 strued to change the option of a State with respect to the
 25 implementation of Medicaid ACA coverage under section

1 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42
 2 U.S.C. 1395a(a)(10)(A)(i)(VIII)), except that a State that
 3 elects not to provide medical assistance to individuals
 4 under such section may make such individuals deposit
 5 qualifying residents under this title.

6 **SEC. 102. STATE ALTERNATIVE OPTION.**

7 (a) IN GENERAL.—In the case of a State that elects
 8 under section 101(a)(3) the alternative option under this
 9 section, subject to subsection (d) and section 105, the fol-
 10 lowing shall apply:

11 (1) NO FEDERAL EXCHANGE.—The Federal
 12 Government shall not establish or maintain an Ex-
 13 change in the State under title I of PPACA.

14 (2) ELIMINATION OF INDIVIDUAL AND EM-
 15 PLOYER SHARED RESPONSIBILITY FOR HEALTH
 16 CARE TAX REQUIREMENTS FOR RESIDENTS AND EM-
 17 PLOYEES IN STATE.—The individual and employer
 18 health care responsibilities under the amendments
 19 made by title I of PPACA (including under sections
 20 5000A and 4980H of the Internal Revenue Code of
 21 1986) shall no longer apply pursuant to section 106
 22 with respect to individuals who are residents of such
 23 State and with respect to individuals who are em-
 24 ployed in such State, respectively.

1 (3) MODIFICATION OF INSURANCE REQUIRE-
2 MENTS.—Except as specifically provided in this title,
3 the requirements under title I of PPACA (including
4 amendments made by such title) relating to health
5 insurance coverage offered in the State shall not
6 apply except to the extent specified by the State.

7 (4) NEW DEPOSIT SYSTEM THROUGH FUNDING
8 HSAS.—

9 (A) IN GENERAL.—Deposit qualifying resi-
10 dents (as defined in subsection (b)(2)) who are
11 residing in the State are eligible for a deposit
12 to a health savings account that may be used
13 for premiums and cost-sharing for health insur-
14 ance coverage in accordance with subsection
15 (b).

16 (B) STATE SPECIFICATION OF MANNER OF
17 CARRYING OUT HSA DEPOSIT SYSTEM (PATIENT-
18 GRANT ELECTING STATE).—In making the elec-
19 tion under this subsection, a State shall specify
20 whether the State will carry out subsection (b)
21 or if such subsection shall be carried out by
22 means of the credit under section 36C of the
23 Internal Revenue Code of 1986.

24 (5) ADDITIONAL AMOUNTS FOR POPULATION
25 HEALTH INITIATIVES FOR STATE ADMINISTERED

1 HSA DEPOSIT SYSTEM.—A patient-grant electing
 2 State (as defined in section 100(1)) is entitled to re-
 3 ceive additional funding under subsection (c) for
 4 population health initiatives.

5 (b) DEPOSIT THROUGH PAYMENT INTO HSA FOR
 6 DEPOSIT QUALIFYING RESIDENTS.—

7 (1) IN GENERAL.—The subsidies described in
 8 subsection (a)(4) for an electing State shall be fur-
 9 nished for each deposit qualifying resident through
 10 the deposit of a contribution into an HSA of the in-
 11 dividual in the amount determined under section
 12 103.

13 (2) DEPOSIT QUALIFYING RESIDENT DE-
 14 FINED.—In this title, the term “deposit qualifying
 15 resident” means, with respect to a State and a
 16 month, an individual—

17 (A) who is a qualified resident (as defined
 18 in section 100(14)) of the State as of the first
 19 day of the month (or such other day in the
 20 month as the Secretary may specify);

21 (B) with respect to whom an HSA has
 22 been established, which HSA may have been es-
 23 tablished by the State in carrying out this sec-
 24 tion;

1 (C) who is enrolled in qualified health plan
 2 coverage (as defined in section 100(13)), which
 3 enrollment may have been effected by the State
 4 in carrying out this section; and

5 (D) who is not eligible for coverage under
 6 Medicare, is not enrolled for benefits under
 7 Medicaid or CHIP, and is not enrolled for bene-
 8 fits under chapter 55 of title 10, United States
 9 Code (relating to TRICARE), or title 39 of
 10 such Code (relating to veterans' benefits) or
 11 chapter 89 of title 5 of such Code (relating to
 12 the Federal Employees Health Benefits Pro-
 13 gram).

14 (3) PAYMENT ADMINISTRATION.—

15 (A) STATE.—In the case of an electing
 16 State that elects to carry out this subsection
 17 through the State, the Secretary shall provide
 18 for payment to the State in amounts and in a
 19 time and manner sufficient to permit the State
 20 to make timely monthly contributions to HSAs
 21 under this subsection. The Secretary may pro-
 22 vide for payment to the State using the pay-
 23 ment methodology described in subsection (d) of
 24 section 1903 of the Social Security Act for pay-
 25 ments under subsection (a) of such section (ap-

1 plied without regard to any State matching re-
 2 quirement) and may condition such payments
 3 upon the provision of such information as the
 4 Secretary may require to ensure the proper pay-
 5 ments under this subsection. As a condition of
 6 receiving payment under this section, a State
 7 shall submit such information, in such form,
 8 and manner, as the Secretary shall specify, in-
 9 cluding information necessary to make the com-
 10 putations of amounts under this section.

11 (B) FEDERAL.—In the case of a State
 12 electing to carry out this subsection other than
 13 through the State, subsidies described in sub-
 14 section (a)(4) shall be provided through a re-
 15 fundable tax credit under section 36C of the In-
 16 ternal Revenue Code of 1986.

17 (4) CONSTRUCTION.—Nothing in this sub-
 18 section shall be construed—

19 (A) to prevent an individual from affirma-
 20 tively electing not to have an HSA established
 21 on the individual's behalf and not to be enrolled
 22 under health insurance coverage;

23 (B) subject to subparagraph (A), to pre-
 24 vent a State from establishing an HSA for each

1 deposit qualifying resident who does not other-
2 wise have an HSA;

3 (C) subject to subparagraph (A), to pre-
4 vent a State from establishing a mechanism
5 whereby individuals who would be deposit quali-
6 fying residents but for paragraph (2)(C) are en-
7 rolled under health insurance coverage; and

8 (D) to prevent a State from changing its
9 State Medicaid plan to eliminate coverage under
10 section 1902(a)(10)(A)(i)(VIII) of the Social
11 Security Act (42 U.S.C.
12 1396a(a)(10)(A)(i)(VIII)), in order that indi-
13 viduals otherwise covered under such section
14 may qualify for subsidies under this section.

15 (c) POPULATION HEALTH INITIATIVE FUNDING.—

16 (1) IN GENERAL.—In the case of an electing
17 State for a year, the State is entitled to receive pay-
18 ment from the Secretary of Health and Human
19 Services after the end of such year in an amount
20 equal to 2 percent of the actual aggregate amount
21 deposited under subsection (b) into HSAs for resi-
22 dents of the State for the year.

23 (2) USE OF FUNDS.—Amounts paid to a State
24 under paragraph (1) may only be used for popu-

1 lation health initiatives (as defined by the Sec-
2 retary).

3 (3) ENTITLEMENT.—Paragraph (1) constitutes
4 budget authority in advance of appropriations Acts
5 and represents the obligation of the Federal Govern-
6 ment to provide for the payment to States of
7 amounts provided under such paragraph.

8 (d) REQUIRING RULES FOR COMPUTING USUAL,
9 CUSTOMARY, AND REASONABLE (UCR) PRICES.—As a
10 condition for a State’s election of the alternative option
11 under this section, the State must provide, through its de-
12 partment of insurance or equivalent agency, for establish-
13 ment of rules to carry out section 1867(j)(1)(A)(ii) of the
14 Social Security Act, as added by section 121(a)(2).

15 **SEC. 103. COMPUTATION OF MONTHLY HSA DEPOSIT**
16 **AMOUNT FOR DEPOSIT QUALIFYING RESI-**
17 **DENTS.**

18 (a) COMPUTATION.—

19 (1) IN GENERAL.—The Secretary shall develop
20 a standardized methodology to determine consistent
21 with this section a monthly HSA deposit amount for
22 deposit qualifying residents in each State for months
23 in each year. Subject to paragraphs (3) and (4),
24 such amount shall be equal to $\frac{1}{12}$ of the average per
25 capita annual amount computed under subsection

1 (b) for the State for the year, as adjusted for the
2 deposit qualifying resident involved—

3 (A) for age and geographic area under
4 subsection (c); and

5 (B) for income under subsection (d).

6 (2) NO VARIATION BASED ON HOW DEPOSIT
7 AMOUNT DISTRIBUTED.—Such amount shall be the
8 same for a deposit qualifying individual without re-
9 gard to whether the contribution to the individual's
10 HSA is made by a State under this section or by the
11 Federal Government through the operation of sec-
12 tion 36C of the Internal Revenue Code of 1986.

13 (3) PATIENT-GRANT ELECTING STATE HAS
14 FLEXIBILITY TO MAINTAIN LEVEL OF BENEFITS FOR
15 CURRENT ACA BENEFICIARIES.—A patient-grant
16 electing State may elect to increase the amount of
17 the deposit for all deposit qualifying individuals
18 under this section to the amounts that the Secretary
19 estimates would have been paid with respect to such
20 individuals under section 36B of the Internal Rev-
21 enue Code of 1986 and section 1402 of PPACA if
22 those sections had remained in effect in the State
23 with respect to such individuals. Such election shall
24 be made for a year and shall continue from year to
25 year until the State elects to terminate such election.

1 (4) SPECIAL RULE FOR PARTIAL DEPOSIT FOR
 2 LOW-INCOME INDIVIDUALS WITH EMPLOYER-SPON-
 3 SORED INSURANCE (ESI).—In the case of an indi-
 4 vidual who is covered under a group health plan and
 5 with respect to such coverage there is a contribution
 6 by an employer which is excluded from the individ-
 7 ual's gross income under the Internal Revenue Code
 8 of 1986, insofar as the individual is a deposit quali-
 9 fying resident, the amount of the deposit with re-
 10 spect to the individual shall be reduced, in a manner
 11 specified by the Secretary in consultation with the
 12 Secretary of the Treasury and taking into account
 13 the income of the individual's household, by an
 14 amount that is approximately equivalent to the esti-
 15 mated amount of the reduction in the amount of in-
 16 come tax resulting from such exclusion (and any re-
 17 duction in taxes imposed by chapter 21 or chapter
 18 2 of such Code by reason of any exclusion of such
 19 contributions from wages and self employment in-
 20 come).

21 (b) COMPUTATION OF UNADJUSTED PER CAPITA.—

22 (1) FOR STATES THAT CONTINUE PPACA MED-
 23 ICAID COVERAGE.—

24 (A) IN GENERAL.—In the case of a State
 25 that provides medical assistance under section

1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)(VIII)) during a year, subject to paragraphs (3) and (4), the Secretary shall compute an average per capita annual amount for the State for the year equal to—

(i) the amount specified in subparagraph (B), divided by

(ii) the average monthly number of deposit qualifying residents of the State in the year.

(B) AMOUNT BASED ON PPACA PROJECTED FEDERAL EXPENDITURES.—The amount specified in this subparagraph for a State for a year is 95 percent of the Secretary’s estimate of the total payments that would have been made (assuming the existence of a State established Exchange in the State) under section 36B of the Internal Revenue Code of 1986 and under section 1402 of PPACA with respect to all qualified residents in the State in the year (or taxable year ending with such year, if applicable).

(2) FOR STATES THAT DO NOT PROVIDE PPACA MEDICAID COVERAGE.—

1 (A) IN GENERAL.—In the case of a State
 2 not described in paragraph (1) for a year, sub-
 3 ject to paragraphs (3) and (4), the Secretary
 4 shall compute an average per capita annual
 5 amount for the State for the year equal to—

6 (i) the amount specified in subpara-
 7 graph (B) for the State and year, divided
 8 by

9 (ii) the average monthly number of
 10 deposit qualifying residents of the State in
 11 the year.

12 (B) AMOUNT BASED ON PPACA AND MED-
 13 ICAID PROJECTED FEDERAL EXPENDITURES.—
 14 The amount specified in this subparagraph for
 15 a State for a year is equal to the sum of—

16 (i) 95 percent of the Secretary's esti-
 17 mate of the total payments that would
 18 have been made (assuming the existence of
 19 a State-established Exchange in the State)
 20 under section 36B of the Internal Revenue
 21 Code of 1986 and under section 1402 of
 22 PPACA with respect to all qualified resi-
 23 dents in the year (or taxable year ending
 24 with such year, if applicable); and

1 (ii) the Secretary's estimate of the
 2 total payments that would have been made
 3 to the State under title XIX of the Social
 4 Security Act for individuals eligible to be
 5 covered under section
 6 1902(a)(10)(A)(i)(VIII) of the Social Secu-
 7 rity Act assuming the election of a State to
 8 provide Medicaid coverage under such sec-
 9 tion and assuming the applicable Federal
 10 medical assistance percentage were 95 per-
 11 cent with respect to such individuals.

12 (3) BUDGET NEUTRAL ADJUSTMENT IN PAY-
 13 MENTS TO TAKE INTO ACCOUNT ELECTION OF HIGH-
 14 ER DEPOSITS TO MAINTAIN ACA SUBSIDY LEVELS.—
 15 If a State makes the election described in subsection
 16 (a)(3) with respect to providing higher deposit
 17 amounts for certain individuals described in such
 18 subsection, then the Secretary shall adjust the aver-
 19 age per capita annual amount under paragraph (1)
 20 or (2), as applicable to the State, by—

21 (A) reducing the amount described in
 22 paragraph (1)(B) (or, if applicable, paragraph
 23 (2)(B)(i)) by an amount equal to 95 percent of
 24 the aggregate increased deposit level attrib-
 25 utable to subsection (a)(3); and

1 (B) not counting such an individual as a
 2 qualifying resident for purposes of paragraph
 3 (1)(A)(ii) (or, if applicable, paragraph
 4 (2)(A)(ii)).

5 (4) ADJUSTMENT FOR COSTS OF PARTIAL DE-
 6 POSITS FOR LOW-INCOME ESI INDIVIDUALS.—The
 7 Secretary shall adjust the average per capita annual
 8 amount under paragraph (1) or (2), as applicable to
 9 the State, by—

10 (A) reducing the amount described in
 11 paragraph (1)(B) (or, if applicable, paragraph
 12 (2)(B)(i)) by an amount equal to 95 percent of
 13 the amount of payments under this section that
 14 are attributable to individuals described in sub-
 15 section (a)(4); and

16 (B) not counting any individual described
 17 in subsection (a)(4) as a qualifying resident for
 18 purposes of paragraph (1)(A)(ii) (or, if applica-
 19 ble, paragraph (2)(A)(ii)).

20 (c) ADJUSTMENT FOR AGE, GEOGRAPHIC AREA, AND
 21 INCOME DISTRIBUTION WITHIN STATE.—

22 (1) IN GENERAL.—The Secretary shall apply
 23 such adjustments to the per capita amount com-
 24 puted under subsection (b) as is designed to take
 25 into account, in a budget neutral manner and based

1 on the costs estimated under paragraph (2), actu-
2 arial differences in health care costs attributable to
3 individuals in different age categories and different
4 geographic locations of primary residences in the
5 State and the reductions based on income under
6 subsection (d). No such adjustment shall be made
7 based on sex.

8 (2) DATA ON AVERAGE COSTS OF SERVICES.—

9 Not later than December 15 before the beginning of
10 each year, the Agency for Healthcare Research and
11 Quality shall estimate the average cost of health
12 care for such year for individuals under 65 years of
13 age and may estimate how such average varies for
14 different populations of individuals under age 65.
15 The adjustments under paragraph (1) for age cat-
16 egories for a year shall be based on such estimates
17 made. Not later than such date, the Secretary shall
18 prescribe tables for purposes of making adjustments
19 based on age under paragraph (1) based on such de-
20 termination which shall apply for taxable years be-
21 ginning in the succeeding calendar year.

22 (d) INCOME-RELATED PHASE-OUT.—

23 (1) IN GENERAL.—The per capita amount as
24 computed under subsection (b) and adjusted and ap-
25 plied to a deposit qualifying individual under sub-

1 section (c) shall be multiplied by a phase-out per-
 2 centage equal to 100 percent reduced by 1 percent-
 3 age point for each \$1,000 (or fraction thereof) by
 4 which the taxpayer’s modified adjusted gross income
 5 for the taxable year exceeds \$90,000 (or, in the case
 6 of a joint return, \$150,000), multiplied, for a tax-
 7 able year ending in a year beginning after December
 8 31, 2015, by the cost-of-living adjustment for the
 9 year as described in section 1(f)(3) of the Internal
 10 Revenue Code of 1986, but substituting “2015” for
 11 “1992” in subparagraph (B) of such section.

12 (2) ZERO PER CAPITA AMOUNT FOR MARRIED
 13 FILING SEPARATELY.—The per capita amount under
 14 this section shall be zero in the case of a married
 15 couple filing separately.

16 **SEC. 104. STATE OPTIONS FOR IMPROVED ACCESS TO**
 17 **HEALTH INSURANCE COVERAGE IN EACH**
 18 **STATE.**

19 (a) STATE OPTIONS TO IMPROVE ACCESS.—

20 (1) IN GENERAL.—Each State may carry out
 21 any of the functions described in succeeding sub-
 22 sections in order to improve the access of residents
 23 of the State to health insurance coverage.

24 (2) REPURPOSING STATE EXCHANGES.—A
 25 State may use or adapt an Exchange that the State

1 has established under title I of PPACA to carry out
2 the any of such functions.

3 (3) REPURPOSING FEDERAL EXCHANGE.—The
4 Federal Government shall make available to States
5 current capabilities of the Federal Exchange, includ-
6 ing the Federal Data Services Hub and Agent
7 Broker Portal, to the extent requested by a State for
8 activities related to enrollment of citizens of the
9 State into health insurance coverage.

10 (b) TRANSPARENCY PORTAL.—Each State may es-
11 tablish and operate an open and transparent marketplace
12 mechanism whereby qualified residents of the State can
13 readily compare, through the use of the Internet, the bene-
14 fits and prices between different health insurance coverage
15 options made available to them.

16 (c) ENROLLMENT, SUBJECT TO INDIVIDUAL OPT-
17 OUT.—

18 (1) IN GENERAL.—Subject to paragraph (2), a
19 State may provide for the enrollment of qualified
20 residents of the State who are uninsured in default
21 health insurance coverage offered under section
22 105(c) and establishing an HSA for such residents
23 who do not have an HSA unless the resident has af-
24 firmatively elected not to be so enrolled and not to
25 have an HSA, respectively. Any such enrollment

1 under this paragraph shall be coordinated with the
 2 annual open enrollment periods provided under sec-
 3 tion 105(b).

4 (2) SIMPLE PROCESS FOR INDIVIDUALS TO OPT-
 5 OUT.—As a condition of a State providing for the
 6 enrollment function described in paragraph (1), the
 7 State must establish an easy-to-use and transparent
 8 means by which individuals may elect not to be en-
 9 rolled in default health insurance coverage or to
 10 have an HSA established on the individual’s behalf,
 11 or both.

12 (d) RISK MITIGATION MECHANISMS AND REINSUR-
 13 ANCE AND RISK-CORRIDOR PROGRAMS.—

14 (1) IN GENERAL.—Notwithstanding any other
 15 provision of this title or section 223(c)(2) of the In-
 16 ternal Revenue Code of 1986, a State may estab-
 17 lish—

18 (A) mechanisms for risk mitigation or risk
 19 adjustment in order to limit volatility in the
 20 premiums based on health experience to class-
 21 average premiums; and

22 (B) a reinsurance and risk-corridor pro-
 23 gram that involves no Federal funds with re-
 24 spect to coverage both in the individual market
 25 and in the small group market.

1 (2) BASIS FOR RISK ADJUSTMENT.—Mecha-
 2 nisms and programs under paragraph (1) may be
 3 based on the health status score of each individual
 4 enrolled in health insurance coverage in the indi-
 5 vidual market and not solely based on the aggregate
 6 risk of the risk pool with respect to each plan of
 7 health insurance coverage.

8 **SEC. 105. EXPANDED ACCESS AND PATIENT PROTECTIONS.**

9 (a) IN GENERAL.—As a condition for the election of
 10 the alternative option under section 102 in a State, the
 11 State must meet the requirements of this section.

12 (b) ANNUAL AND OTHER OPEN ENROLLMENT PERI-
 13 ODS.—

14 (1) IN GENERAL.—The State shall require, in
 15 connection with the offering of health insurance cov-
 16 erage in the individual market in the State, that
 17 there are uniform annual and other open enrollment
 18 periods (such as those for changes in life events,
 19 changes in State residency, and involuntary changes
 20 in eligibility for coverage under a group health plan)
 21 in order to permit qualified residents to enroll in
 22 qualified health plan coverage in a manner that pro-
 23 motes continuity of coverage. Such periods shall be
 24 consistent with the open enrollment periods estab-

lished under title I of PPACA, as in effect on the day before the date of the enactment of this Act.

(2) INITIAL OPEN ENROLLMENT PERIOD.—In addition, the State shall establish an initial open enrollment period during which qualified residents may enroll in qualified health plan coverage without the imposition of any underwriting described in subsection (d)(1)(B). Such period shall be a period of not less than 45 days and shall provide for enrollment to become effective on January 1 of the year specified by the State in which such State election first becomes effective.

(c) OFFERING OF DEFAULT HEALTH INSURANCE COVERAGE.—

(1) IN GENERAL.—The State shall provide for the offering, through one or more contracts with one or more health insurance issuers in the State, of default health insurance coverage (as defined in paragraph (2)) to qualified residents of the State who are otherwise uninsured. Such default coverage shall be made available on a continuous basis during a year. Failure of a qualified resident to enroll in such default coverage or other creditable coverage during a year results in adverse consequences described in subsection (d)(1)(B) to the resident.

1 (2) DEFAULT HEALTH INSURANCE PLAN DE-
 2 FINED.—In this title, the term “default health in-
 3 surance plan” means, with respect to a State, health
 4 insurance coverage that—

5 (A) is a high deductible health plan (within
 6 the meaning of section 223(c)(2) of the Internal
 7 Revenue Code of 1986) with prescription drug
 8 coverage limited to generic drugs for a limited
 9 number of chronic conditions (commonly re-
 10 ferred to as tier I pharmacy benefit);

11 (B) meets such requirements as may apply
 12 to qualify for the payment of plan premiums
 13 from a health savings account under section
 14 223 of such Code (such as age-related pre-
 15 miums and limitation on imposition of pre-
 16 existing condition exclusions);

17 (C) has a provider network for covered
 18 benefits that is adequate (as determined con-
 19 sistent with guidelines issued by the Secretary)
 20 to ensure access to health benefits under such
 21 plan;

22 (D) provides for coverage of childhood im-
 23 munizations without cost sharing requirements
 24 to the extent such immunizations have in effect
 25 a recommendation from the Advisory Com-

mittee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

(E) meets such other requirements as the State may specify.

(d) CONSEQUENCES RESPECTING CONTINUOUS COVERAGE.—

(1) CONSEQUENCES FOR NOT MAINTAINING CONTINUOUS COVERAGE.—

(A) AVOIDANCE OF CONSEQUENCES BY MAINTAINING CONTINUOUS COVERAGE.—All qualified residents of a State are eligible during the initial open enrollment period provided under subsection (b)(2) to enroll in qualified health plan coverage and, thereafter, to maintain continuous coverage in order to avoid the adverse consequences described in the succeeding provisions of this paragraph.

(B) UNDERWRITING PERMITTED.—In the case of a qualified resident of the State who fails to maintain continuous creditable coverage (not including any breaks in coverage of less than 63 days), the State shall—

(i) permit health insurance issuers for the period specified in subparagraph (C) to

1 medically underwrite (through denial of
 2 health insurance coverage, application of
 3 preexisting condition limitations, differen-
 4 tial premiums, or otherwise) the issuance
 5 of health insurance coverage, other than
 6 with respect to the issuance of default
 7 health insurance coverage under subsection
 8 (c); and

9 (ii) require health insurance issuers,
 10 during the subsequent 2-year period in the
 11 case of issuance of health insurance cov-
 12 erage other than such default health insur-
 13 ance coverage, to impose a monthly late
 14 enrollment penalty in the amount specified
 15 in subparagraph (D)(i) and to remit the
 16 amount of such penalty collected to the
 17 Federal Treasury in accordance with sub-
 18 paragraph (D)(ii).

19 (C) PERIOD FOR APPLICATION OF UNDER-
 20 WRITING.—For purposes of subparagraph
 21 (B)(i), the period specified in this subparagraph
 22 is, with respect to an uninsured individual as of
 23 a date, a period (not to exceed 18 months)
 24 equivalent to number of months in the previous
 25 18-month period in which the individual did not

1 have continuous creditable coverage described in
 2 subparagraph (B).

3 (D) MONTHLY LATE ENROLLMENT PEN-
 4 ALTY AMOUNT.—

5 (i) IN GENERAL.—The monthly late
 6 enrollment penalty amount specified in this
 7 clause for a month is equal to the lesser of
 8 10 percent or the product of—

9 (I) 1 percent of the monthly pre-
 10 mium amount for default health in-
 11 surance coverage with respect to the
 12 individual and month; and

13 (II) the number of months dur-
 14 ing the 2-year period (preceding the
 15 18-month period described in subpara-
 16 graph (B)(i)) in which the resident
 17 failed to maintain the continuous cov-
 18 erage described in paragraph (1)(D).

19 (ii) PAYMENT OF PENALTY AMOUNT
 20 TO FEDERAL TREASURY.—The amount of
 21 the monthly late enrollment penalty col-
 22 lected under this subparagraph shall be
 23 paid to the Treasury of the United States
 24 in a form and manner specified by the Sec-
 25 retary of the Treasury.

1 (2) CHANGES IN ENROLLMENT PERMITTED
2 WITHOUT MEDICAL UNDERWRITING DURING ANNUAL
3 OPEN ENROLLMENT PERIODS FOR THOSE MAINTAIN-
4 ING CONTINUOUS COVERAGE.—

5 (A) DURING SECOND OPEN ENROLLMENT
6 PERIOD.—In the case of a qualified resident
7 who maintains continuous coverage (not includ-
8 ing any breaks in coverage of less than 63
9 days) during the period after the initial open
10 enrollment period under subsection (b)(2) and
11 through the second annual open enrollment pe-
12 riod established by the State consistent with
13 subsection (b)(1), the State shall require health
14 insurance issuers to permit such residents dur-
15 ing such second annual open enrollment period
16 to change the qualified health plan coverage in
17 which the individual is enrolled without medical
18 underwriting.

19 (B) DURING THIRD AND SUBSEQUENT
20 OPEN ENROLLMENT PERIODS.—In the case of a
21 qualified resident who maintains continuous
22 coverage for a period of 18 months or longer
23 (not including any breaks in coverage of less
24 than 63 days) as of the initial date of a third
25 or subsequent annual open enrollment period

1 established by the State under subsection
 2 (b)(1), the State shall require health insurance
 3 issuers to permit such residents during such an
 4 open enrollment period to change the qualified
 5 health plan coverage in which the individual is
 6 enrolled without medical underwriting.

7 **SEC. 106. SUNSETTING CERTAIN ACA PROVISIONS; CON-**
 8 **TINUATION OF POLICIES OF COVERING**
 9 **ADULT CHILDREN AND NOT APPLYING LIFE-**
 10 **TIME OR ANNUAL LIMITS.**

11 (a) IN GENERAL.—Subject to subsections (b) and (c),
 12 title I of the Patient Protection and Affordable Care Act
 13 (including the amendments made by such title) shall not
 14 apply (and the provisions of law amended by such title
 15 are restored as if such title had not been enacted) in the
 16 case of any State that does not have in effect the election
 17 described in section 101(a)(1).

18 (b) CONTINUATION OF POLICIES FOR EXTENSION OF
 19 DEPENDENT COVERAGE FOR ADULT CHILDREN AND
 20 PROHIBITION OF LIFETIME AND ANNUAL COVERAGE
 21 LIMITS.—Subsection (a) shall not apply with respect to
 22 the following:

23 (1) Section 2711 of the Public Health Service
 24 Act (relating to no lifetime or annual limits).

1 (2) Section 2714 of such Act (relating to exten-
2 sion of dependent coverage).

3 (c) CONTINUATION OF POLICIES FOR CERTAIN
4 STATES OPERATING EXCHANGES.—Subsection (a) shall
5 not apply with respect to health insurance coverage in a
6 State that has in effect the election described in section
7 101(a)(1).

8 **Subtitle B—Medicaid**

9 **SEC. 111. APPLICATION OF HEALTH SAVINGS ACCOUNTS IN** 10 **RELATION TO MEDICAID.**

11 (a) IN GENERAL.—Title XIX of the Social Security
12 Act (42 U.S.C. 1396 et seq.) is amended by adding at
13 the end the following new section:

14 **“SEC. 1947. PROVISIONS RELATING TO HEALTH SAVINGS** 15 **ACCOUNTS.**

16 “(a) DISREGARDING HSA IN DETERMINING ASSETS
17 AND INCOME FOR MEDICAID ELIGIBILITY DETERMINA-
18 TIONS OTHER THAN FOR LONG-TERM CARE SERVICES.—
19 The assets in a health savings account under section 223
20 of the Internal Revenue Code of 1986, and any income
21 from such assets in such account, shall be disregarded for
22 purposes of determining eligibility and amount of medical
23 assistance under this title, other than for purposes of de-
24 termining eligibility and the amount of medical assistance

1 for long-term care services (described in section
2 1917(c)(1)(C)(i)).

3 “(b) NOTIFICATIONS OF TREASURY OF MEDICAID
4 ELIGIBILITY.—In order to meet the requirements of this
5 subsection (for purposes of section 1902(a)(78)), a State
6 shall provide such notice to the Secretary of the Treasury,
7 in such form and manner as such Secretary shall specify,
8 as may be necessary to identify individuals who are eligible
9 for, and receiving, medical assistance under this title in
10 a month in order to carry out section 223 of the Internal
11 Revenue Code of 1986.”.

12 (b) IMPLEMENTATION OF NOTIFICATION REQUIRE-
13 MENT THROUGH STATE PLAN.—Section 1902(a) of the
14 Social Security Act (42 U.S.C. 1396a(a)) is amended by
15 inserting after paragraph (77) the following new para-
16 graph:

17 “(78) provide for notice in accordance with sec-
18 tion 1947(b) to the Secretary of the Treasury of the
19 identity of individuals who are determined eligible
20 for (and receiving) medical assistance under this
21 title;”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to eligibility determinations with
24 respect to medical assistance for periods beginning on or
25 after January 1, 2016.

**Subtitle C—Provider Price
Transparency**

**SEC. 121. ENSURING ACCESS TO EMERGENCY SERVICES
WITHOUT EXCESSIVE CHARGES FOR OUT-OF-
NETWORK SERVICES.**

(a) IN GENERAL.—Section 1867 of the Social Security Act (42 U.S.C. 1395dd) is amended—

(1) in subsection (d), by adding at the end the following new paragraph:

“(5) ENFORCEMENT WITH RESPECT TO EXCESSIVE CHARGES.—A hospital, physician, or other entity that violates the requirements of subsection (j)(1) with respect to the furnishing of items and services is subject to a civil money penalty of not more than \$25,000 for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).”; and

(2) by adding at the end the following new subsection:

“(j) PROTECTIONS AGAINST EXCESSIVE OUT-OF-NETWORK CHARGES FOR EMERGENCY SERVICES.—

1 “(1) IN GENERAL.—If items or services to
 2 screen or treat an emergency medical condition are
 3 furnished under this section in a participating hos-
 4 pital with respect to an individual and the individual
 5 has not, directly or through a health insurance
 6 issuer, group health plan, or other third party, nego-
 7 tiated a payment rate for such items and services,
 8 subject to paragraph (2), the charges imposed for
 9 such items and services may not be in excess of the
 10 following:

11 “(A) PHYSICIANS’ AND OTHER PROFES-
 12 SIONAL SERVICES.—For physicians’ services or
 13 services of a health care provider to which sec-
 14 tion 223(e)(9) of the Internal Revenue Code of
 15 1986 applies (and including drugs and
 16 biologicals furnished in conjunction with and
 17 billed as part of such services), the lesser of—

18 “(i) the cash price for such services
 19 posted pursuant to such section; or

20 “(ii) 85 percent of the usual, cus-
 21 tomary, and reasonable (UCR) charge for
 22 such services, as determined under rules
 23 established by the department of insurance
 24 for the State in which the services are fur-
 25 nished.

“(B) HOSPITAL SERVICES.—For inpatient and outpatient hospital services for which payment rates are established under this title (and including drugs and biologicals furnished in conjunction with and billed as part of such services), the lesser of—

“(i) the cash price for such services posted pursuant to section 223(e)(9) of the Internal Revenue Code of 1986; or

“(ii) 110 percent of the payment rate applicable to such services in the case of an individual entitled to benefits under part A and enrolled under part B.

“(C) DRUGS AND BIOLOGICALS.—For drugs and other pharmaceuticals furnished to which a previous subparagraph does not apply, the lesser of—

“(i) twice the acquisition cost to the hospital or other provider for the dose involved; or

“(ii) the acquisition cost to the hospital or other provider plus \$250.

The dollar amount in clause (ii) shall be increased from year to year (beginning with the year after the first year in which this subsection

1 applies) by the same percentage as the percent-
 2 age increase in the consumer price index for all
 3 urban consumers (all items; U.S. city average)
 4 for the year involved (as determined by the Sec-
 5 retary). Any such dollar amount as so increased
 6 that is not a multiple of \$5 shall be rounded to
 7 the nearest multiple of \$5 (or, if a multiple of
 8 \$2.50, to the next highest multiple of \$5).

9 “(D) OTHER ITEMS AND SERVICES.—For
 10 any other items or services, the lesser of—

11 “(i) the cash price for such items and
 12 services posted pursuant to section
 13 223(e)(9) of the Internal Revenue Code of
 14 1986; or

15 “(ii) 110 percent of the payment basis
 16 that would be applicable to payment for
 17 such items and services under this title in
 18 the case of an individual entitled to bene-
 19 fits under part A and enrolled under part
 20 B.

21 “(2) SPECIAL RULE FOR ITEMS AND SERVICES
 22 FURNISHED AS A BUNDLE.—In the case of items
 23 and services for which there is a single price for a
 24 group or bundle of such items and services, the max-

1 imum charge permitted under paragraph (1) may
2 not exceed the lesser of—

3 “(A) the price charged for such bundled
4 services; or

5 “(B) the aggregate of the maximum
6 charges permitted under paragraph (1) with re-
7 spect to items and services included in such
8 bundle.”.

9 (b) REFERENCE TO PRICE DISCLOSURE PROVI-
10 SION.—For requirements relating to the posting of health
11 care prices on the Internet, see section 223(e)(9) of the
12 Internal Revenue Code of 1986, as added by section
13 204(a).

14 (c) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to charges imposed for items and
16 services furnished on or after January 1, 2016.

17 **TITLE II—REFORM OF TAX PRO-**
18 **VISIONS RELATING TO**
19 **HEALTH CARE**
20 **Subtitle A—Promotion of Health**
21 **Savings Accounts**

22 **SEC. 201. REPEAL OF HIGH DEDUCTIBLE HEALTH PLAN RE-**
23 **QUIREMENT.**

24 (a) IN GENERAL.—Section 223(a) of the Internal
25 Revenue Code of 1986 is amended to read as follows:

1 “(a) DEDUCTION ALLOWED.—In the case of an indi-
 2 vidual, there shall be allowed as a deduction for a taxable
 3 year an amount equal to the aggregate amount paid in
 4 cash during such taxable year by or on behalf of such indi-
 5 vidual to a health savings account of such individual.”.

6 (b) CONFORMING AMENDMENTS.—

7 (1) Section 223(b)(1) of such Code is amended
 8 by striking “that the individual is an eligible indi-
 9 vidual”.

10 (2) Section 223(b)(2) of such Code is amended
 11 by striking “under a high deductible health plan”
 12 each place it appears.

13 (3) Section 223(b) of such Code is amended by
 14 striking paragraph (8).

15 (4) Section 223 of such Code is amended by
 16 striking subsection (c) and redesignating subsections
 17 (d) through (h) as subsections (c) through (g), re-
 18 spectively.

19 (5) Section 223(c)(1)(A) of such Code, as re-
 20 designated by this Act, is amended by striking “sub-
 21 section (f)(5)” and inserting “subsection (e)(5)”.

22 (6) Section 223(f)(1) of such Code, as redesign-
 23 nated by this Act, is amended—

24 (A) by striking “subsections (b)(2) and
 25 (c)(2)(A)” and inserting “subsection (b)(2)”,

1 (B) by striking “subparagraph (B) there-
 2 of—” and all that follows through the end of
 3 subparagraph (B) and inserting “subparagraph
 4 (B) thereof ‘calendar year 1997’.”, and

5 (C) by striking “amounts under sub-
 6 sections (b)(2) and (c)(2)(A)” in the second
 7 sentence and inserting “amounts under sub-
 8 section (b)(2)”.

9 (7) Section 26(b)(2)(U) of such Code is amend-
 10 ed by striking “section 223(f)(4)” and inserting
 11 “section 223(e)(4)”.

12 (8) Sections 35(g)(3), 220(f)(5)(A),
 13 848(e)(1)(B)(v), 4973(a)(5), and 6051(a)(12) of
 14 such Code are each amended by striking “section
 15 223(d)” each place it appears and inserting “section
 16 223(c)”.

17 (9) Section 106(d)(1) of such Code is amend-
 18 ed—

19 (A) by striking “who is an eligible indi-
 20 vidual (as defined in section 223(c)(1))”, and

21 (B) by striking “section 223(d)” and in-
 22 serting “section 223(c)”.

23 (10) Section 408(d)(9) of such Code is amend-
 24 ed—

1 (A) in subparagraph (A) by striking “who
 2 is an eligible individual (as defined in section
 3 223(c)) and”, and

4 (B) in subparagraph (C) by striking “com-
 5 puted on the basis of the type of coverage under
 6 the high deductible health plan covering the in-
 7 dividual at the time of the qualified HSA fund-
 8 ing distribution”.

9 (11) Section 877A(g)(6) of such Code is
 10 amended by striking “223(f)(4)” and inserting
 11 “223(e)(4)”.

12 (12) Section 4973(g) of such Code is amend-
 13 ed—

14 (A) by striking “section 223(d)” and in-
 15 serting “section 223(c)”,

16 (B) by striking “223(f)(5)” in paragraph
 17 (1) and inserting “223(e)(5)”,

18 (C) by striking “section 223(f)(2)” in
 19 paragraph (2) and inserting “section
 20 223(e)(2)”, and

21 (D) by striking “section 223(f)(3)” in the
 22 second sentence and inserting “section
 23 223(e)(3)”.

24 (13) Section 4975 of such Code is amended—

25 (A) in subsection (c)(6)—

1 (i) by striking “section 223(d)” and
 2 inserting “section 223(c)”, and
 3 (ii) by striking “section 223(e)(2)”
 4 and inserting “section 223(d)(2)”, and
 5 (B) in subsection (e)(1)(E), by striking
 6 “section 223(d)” and inserting “section
 7 223(c)”.

8 (14) Section 6693(a)(2)(C) of such Code is
 9 amended by striking “section 223(h)” and inserting
 10 “section 223(g)”.

11 (c) EFFECTIVE DATE.—The amendments made by
 12 this section shall apply to taxable years beginning after
 13 December 31, 2015.

14 **SEC. 202. TREATMENT OF HSA AFTER DEATH OF ACCOUNT**
 15 **BENEFICIARY.**

16 (a) IN GENERAL.—Section 223(e)(8) of the Internal
 17 Revenue Code of 1986, as redesignated by section
 18 201(c)(3) of this Act, is amended to read as follows:

19 “(8) TREATMENT AFTER DEATH OF ACCOUNT
 20 BENEFICIARY.—If an individual acquires an account
 21 beneficiary’s interest in a health savings account by
 22 reason of the death of the account beneficiary, such
 23 health savings account shall be treated as if the indi-
 24 vidual were the account beneficiary.”.

1 (b) EFFECTIVE DATE.—The amendment made by
 2 this section shall apply with respect to interests acquired
 3 after the date of the enactment of this Act.

4 **SEC. 203. PURCHASE OF HEALTH INSURANCE FROM HSA**
 5 **ACCOUNT.**

6 (a) IN GENERAL.—Section 223(c)(2) of the Internal
 7 Revenue Code of 1986, as redesignated by section
 8 201(c)(3), is amended—

9 (1) in subparagraph (C)—

10 (A) by striking “or” at the end of clause
 11 (iii),

12 (B) by striking the period at the end of
 13 clause (iv) and inserting “, and”, and

14 (C) by adding at the end the following new
 15 clause:

16 “(v) in the case of health insurance
 17 that meets the requirements of subpara-
 18 graph (D).”; and

19 (2) by adding at the end the following new sub-
 20 paragraphs:

21 “(D) REQUIREMENTS.—The requirements
 22 of this subparagraph are as follows:

23 “(i) OPEN ENROLLMENT WITHOUT
 24 PREEXISTING CONDITION EXCLUSIONS.—

25 The health insurance coverage or group

1 health plan must permit, during uniform
 2 initial and annual open enrollment periods
 3 and for special enrollment periods (such as
 4 the loss of coverage through the loss of
 5 employment) specified in carrying out sec-
 6 tion 105(b) of the Patient Freedom Act of
 7 2015, any individual who has period of
 8 continuous coverage of not less than 18
 9 months who is otherwise eligible to enroll
 10 under such coverage or plan to be so en-
 11 rolled without the imposition of any pre-
 12 existing condition exclusion (as defined for
 13 purposes of title XXVII of the Public
 14 Health Service Act).

15 “(ii) CLASS BASED PREMIUMS FOR
 16 BASIC BENEFITS.—

17 “(I) IN GENERAL.—The premium
 18 for such coverage or plan shall be es-
 19 tablished based on class-average sta-
 20 tus and may vary by age and geo-
 21 graphic area, but may not vary based
 22 upon the health status of the indi-
 23 vidual, except that in the case of an
 24 individual without continuous cov-
 25 erage for a period of 42 months, such

1 premium may be increased above the
 2 class-average in the manner and for
 3 the time period specified in section
 4 105(d)(1)(A)(ii) of the Patient Free-
 5 dom Act of 2015.

6 “(II) ESTABLISHMENT OF ACTU-
 7 ARIAL TABLES.—In carrying out sub-
 8 clause (I), the Secretary shall enter
 9 into a contract with a qualified orga-
 10 nization, such as the Academy of Ac-
 11 tuaries, for the development of actu-
 12 arial tables to calculate class-average
 13 rates based on age and geography.

14 “(E) CONTINUOUS COVERAGE.—For pur-
 15 poses of this paragraph, an individual shall be
 16 considered to have continuous coverage as of a
 17 time if the individual has no continuous period
 18 in which the individual is uninsured (as defined
 19 in section 100 of the Patient Freedom Act of
 20 2015) for longer than 63 days beginning after
 21 the date of the enactment of such Act.”.

22 (b) EFFECTIVE DATE.—The amendments made by
 23 this section shall apply to taxable years beginning after
 24 December 31, 2015.

1 **SEC. 204. PUBLISHING OF CASH PRICE FOR CARE PAID**
 2 **THROUGH HEALTH SAVINGS ACCOUNTS.**

3 (a) IN GENERAL.—Section 223(e) of the Internal
 4 Revenue Code of 1986, as redesignated by section
 5 201(c)(3), is amended by adding at the end the following
 6 new paragraph:

7 “(9) CASH PRICE TRANSPARENCY REQUIRED
 8 FOR PAYMENTS TO HEALTH CARE PROVIDERS.—

9 “(A) IN GENERAL.—A payment to a health
 10 care provider with respect to the furnishing of
 11 health care items and services by such provider
 12 shall not be treated as a qualified medical ex-
 13 pense unless health care provider provides for
 14 continuing disclosure (such as through posting
 15 on a publicly accessible website) of the cash
 16 price the health care provider charges for the
 17 furnishing of such items and services.

18 “(B) FORM OF DISCLOSURE.—The disclo-
 19 sure of prices under this subsection shall be in
 20 a form and manner specified by the Secretary
 21 of Health and Human Services, in consultation
 22 with the Secretary, and shall be designed—

23 “(i) to establish a single price for re-
 24 lated items and services in a manner simi-
 25 lar to the manner in which pricing and
 26 payment for such items and services is pro-

1 vided under the Medicare program under
2 title XVIII of the Social Security Act, and

3 “(ii) to make it easy for consumers to
4 compare the prices for similar items and
5 services furnished by different providers.

6 “(C) FAILURE TO FURNISH SERVICES OR
7 CHARGE IN EXCESS OF STATED PRICE.—A
8 health care provider shall be treated as not
9 meeting the requirement of subparagraph (A),
10 in the case of items and services for which the
11 provider is disclosing a cash price, if the pro-
12 vider—

13 “(i) refuses to furnish such items or
14 services at the price listed, or

15 “(ii) charges more than the price list-
16 ed for the furnishing of the items and serv-
17 ices.”.

18 (b) ENFORCEMENT.—If the Secretary of Health and
19 Human Services determines that a health care provider
20 has not provided for continuing disclosure of the cash
21 price of health care provider charges under section
22 223(e)(9) of the Internal Revenue Code of 1986, the Sec-
23 retary may instruct the Secretary of the Treasury that
24 payments made to such provider shall be not treated, for
25 purposes of section 223 of the Internal Revenue Code of

1 1986, as an amount used for a qualified medical expense
 2 for a period of not to exceed 1 year.

3 (c) EFFECTIVE DATE.—The amendments made by
 4 this section shall apply to taxable years beginning after
 5 December 31, 2015.

6 **Subtitle B—Health Care Tax** 7 **Credits**

8 **SEC. 211. LIMITED APPLICATION OF PPACA HEALTH PRE-** 9 **MIUM CREDIT.**

10 (a) IN GENERAL.—Section 36B(c)(1) of the Internal
 11 Revenue Code of 1986 is amended by adding at the end
 12 the following:

13 “(E) SPECIAL RULE FOR RESIDENTS OF
 14 STATES CONTINUING PPACA IMPLEMENTA-
 15 TION.—No credit shall be allowed under this
 16 section to any individual who is not a qualified
 17 resident (as defined in section 100(14) of the
 18 Patient Freedom Act of 2015) of a State that
 19 has elected the option under section 101(a)(1)
 20 of such Act in relation to the implementation of
 21 title I of the Patient Protection and Affordable
 22 Care Act.”.

23 (b) EFFECTIVE DATE.—The amendment made by
 24 this section shall apply to taxable years beginning after
 25 December 31, 2015.

1 **SEC. 212. NEW HSA CREDIT.**

2 (a) IN GENERAL.—Subpart C of part IV of sub-
 3 chapter A of chapter 1 of the Internal Revenue Code of
 4 1986 is amended by inserting after section 36B the fol-
 5 lowing new section:

6 **“SEC. 36C. HSA CREDIT.**

7 “(a) IN GENERAL.—In the case of a qualifying indi-
 8 vidual, there shall be allowed as a credit against the tax
 9 imposed by this subtitle for any taxable year, an amount
 10 equal to the HSA credit amount of the individual for the
 11 taxable year.

12 “(b) QUALIFYING INDIVIDUAL.—For purposes of this
 13 section, the term ‘qualifying individual’ means, with re-
 14 spect to any month, any individual who for such month
 15 is a deposit qualifying resident (as defined in section
 16 102(b)(2) of the Patient Freedom Act of 2015) of a State
 17 described in section 101(a)(3) of such Act that elects to
 18 have section 102(b) of such Act carried out by way of the
 19 credit determined under this section.

20 “(c) HSA CREDIT AMOUNT.—For purposes of this
 21 section, the term ‘HSA credit amount’ means, with respect
 22 to any taxable year, the sum of the HSA deposit amounts
 23 determined under section 103 of the Patient Freedom Act
 24 of 2015 with respect to the individual for all months end-
 25 ing during the taxable year.

1 “(d) SPECIAL RULES.—For purposes of this sec-
2 tion—

3 “(1) RECONCILIATION OF CREDIT AND AD-
4 VANCE CREDIT.—

5 “(A) EXCESS ADVANCE PAYMENTS.—If the
6 advance payments to an individual for a taxable
7 year under subsection (e) exceed the credit al-
8 lowed by this section with respect to such indi-
9 vidual for such taxable year, the tax imposed by
10 this chapter for the taxable year shall be in-
11 creased by the amount of such excess.

12 “(B) ADVANCE PAYMENT SHORTFALL.—If
13 the credit allowed by this section (determined
14 without regard to this subparagraph) with re-
15 spect to an individual for a taxable year exceeds
16 the advance payments to such individual for
17 such taxable year under subsection (e), the Sec-
18 retary shall, in lieu of a credit allowed against
19 the tax imposed by this subtitle, make a pay-
20 ment on behalf of such individual to such indi-
21 vidual’s health savings account in an amount
22 equal to such excess.

23 “(2) MARRIED COUPLES MUST FILE JOINT RE-
24 TURN.—If the taxpayer is married (within the mean-
25 ing of section 7703) at the close of the taxable year,

1 the credit shall be allowed under this section only if
2 the taxpayer and the taxpayer's spouse file a joint
3 return for the taxable year.

4 “(e) ADVANCE PAYMENT PROGRAM.—

5 “(1) IN GENERAL.—The Secretary of the
6 Treasury, in consultation with the Secretary of
7 Health and Human Services, shall establish a pro-
8 gram—

9 “(A) to make advance determinations with
10 respect to the eligibility of individuals for the
11 credit allowed under this section, and

12 “(B) to make advance payments of the
13 credit allowed under this section directly to the
14 health savings account of any such individual so
15 eligible.

16 “(2) PROGRAM REQUIREMENTS.—Such pro-
17 gram shall be established under rules similar to the
18 rules of section 1412 of the Patient Protection and
19 Affordable Care Act, except that advance determina-
20 tions and advance payments shall be made on re-
21 quest of the individual with respect to whom the de-
22 termination is to be made and taking into account
23 the enrollment process (including any opt-out elec-
24 tion under such process) established under section
25 104(c)(1) of the Patient Freedom Act of 2015.”.

1 (b) CLERICAL AMENDMENT.—The table of sections
2 for such subpart is amended by inserting after the item
3 relating to section 36B the following new item:

“Sec. 36C. HSA credit.”.

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to taxable years beginning after
6 December 31, 2015.

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